

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/26/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155664</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>11/22/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>4102 SHORE DR</b> <b>INDIANAPOLIS, IN 46254</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00136364, IN00136393, IN00136405, IN00136448, IN00138957, and IN00139626.</p> <p>Complaint IN00136364 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00136393 Unsubstantiated due to lack of evidence.</p> <p>Complaint IN136405 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00136448 Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00138597 Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00139626 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: November 19, 20, 21, 22, 2013</p> <p>Facility number: 010666 Provider number: 155664 AIM number: 200229930</p> <p>Survey team: Connie Landman RN-TC Joyce Hoffman RN (November 20, 21, 22, 2013)</p> <p>Census bed type: SNF/NF: 100 Total: 100</p> <p>Census payor type:</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	<p>Continued From page 1</p> <p>Medicare: 39 Medicaid: 37 Other: 24 Total: 100</p> <p>Sample: 10</p> <p>Kindred Transitional Care and Rehab - Eagle Creek was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00136364, IN00136393, IN00136405, IN00136448, IN00138957, and IN00139626.</p> <p>Quality Review 11/25/13 by Lisa McColly</p>	F 000			